FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031385

Facility Name: SKOKIE MEADOWS N CENTER #1

Address: 9615 N. KNOX AVE. (Number) SKOKIE (City) 60076 (Zip Code)

County: COOK

Telephone Number: (847) 679-4161 **Fax #** (847) 679-3241

IDPA ID Number: 36-3481217

Date of Initial License for Current Owners: 3/23/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) JACOB GRAFF
(Title)

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	113	Skilled (SNF)	113	41,358	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,358	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,070	4,619	4,331	38,020	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,070	4,619	4,331	38,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 91.93%

D. How many bed-hold days during this year were paid by Public Aid? 443 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/23/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/23/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2320

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	161,858	10,212	9,070	181,140		181,140	0	181,140			1
2	Food Purchase		139,542		139,542	(10,340)	129,202	(195)	129,007			2
3	Housekeeping	102,783	13,076	0	115,859		115,859	0	115,859			3
4	Laundry	46,483	21,153	0	67,636		67,636	0	67,636			4
5	Heat and Other Utilities			67,803	67,803		67,803	197	68,000			5
6	Maintenance	0	12,842	36,330	49,172		49,172	(1,145)	48,027			6
7	Other (specify):*			8,141	8,141		8,141	0	8,141			7
8	**TOTAL General Services**	311,124	196,825	121,344	629,293	(10,340)	618,953	(1,143)	617,810			8
	B. Health Care and Programs											
9	Medical Director			1,470	1,470		1,470	0	1,470			9
10	Nursing and Medical Records	1,320,564	113,358	52,432	1,486,354		1,486,354	0	1,486,354			10
10a	Therapy	0		174,208	174,208	(170,083)	4,125	0	4,125			10a
11	Activities	58,888	6,179	968	66,035		66,035	0	66,035			11
12	Social Services	77,116		4,704	81,820		81,820	0	81,820			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			779	779		779	0	779			14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,456,568	119,537	234,561	1,810,666	(170,083)	1,640,583		1,640,583			16
	C. General Administration											
17	Administrative	116,309		341,005	457,314		457,314	(313,592)	143,722			17
18	Directors Fees			0				0				18
19	Professional Services			60,330	60,330		60,330	744	61,074			19
20	Dues, Fees, Subscriptions & Promotions			57,270	57,270		57,270	(42,173)	15,097			20
21	Clerical & General Office Expense	43,674	13,266	280,352	337,292		337,292	(174,662)	162,630			21
22	Employee Benefits & Payroll Taxes			307,850	307,850	10,340	318,190	0	318,190			22
23	Inservice Training & Education			9,985	9,985		9,985	40	10,025			23
24	Travel and Seminar			0				0				24
25	Other Admin. Staff Transportation			16,293	16,293		16,293	(4,178)	12,115			25
26	Insurance-Prop.Liab.Malpractice			41,277	41,277		41,277	0	41,277			26
27	Other (specify):*			0				16,195	16,195			27
28	**TOTAL General Administration**	159,983	13,266	1,114,362	1,287,611	10,340	1,297,951	(517,626)	780,325			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,927,675	329,628	1,470,267	3,727,570	(170,083)	3,557,487	(518,769)	3,038,718			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			120,074	120,074		120,074	13,796	133,870			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			558,403	558,403		558,403	(45,470)	512,933			32
33	Real Estate Taxes			173,448	173,448		173,448	0	173,448			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			40,591	40,591		40,591	5,988	46,579			35
36	Other (specify):* amort mtg costs			16,426	16,426		16,426	0	16,426			36
37	TOTAL Ownership			908,942	908,942		908,942	(25,686)	883,256			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					170,083	170,083	0	170,083			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			62,037	62,037		62,037	0	62,037			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			62,037	62,037	170,083	232,120		232,120			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,927,675	329,628	2,441,246	4,698,549	0	4,698,549	(544,455)	4,154,094			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	13,796	30		9
10	Interest and Other Investment Income	(31,870)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(195)	2		13
14	Non-Care Related Interest	(13,600)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,178)	25		16
17	Non-Care Related Fees	(1,100)	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(35,078)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(6,366)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(1,145)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,786)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(464,669)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (464,669)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (544,455)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name SKOKIE MEADOWS N CENTER #1

IDP 0031305

Report Period Beginning: 01/01/2008

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line 1	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0		
2	**Other Care for Outpatients**	0	0		
3	**Governmental Sponsored Special Programs**	0	0		
4	**Non-Patient Meals**	0	2		
5	**Telephone, TV & Radio in Resident Rooms**	0	0		
6	**Rented Facility Space**	0	34		
7	**Sale of Supplies to Non-Patients**	0	10		
8	**Laundry for Non-Patients**	0	4		
9	**Non-Straightline Depreciation**	13,706	30		
10	**Interest and Other Investment Income**	(31,870)	32		
11	**Discounts, Allowances, Rebates & Refunds**	0	2		
12	**Non-Working Officer's or Owner's Salary**	0	0		
13	**Sales Tax**	(195)	2		
14	**Non-Care Related Interest**	(13,600)	32		
15	**Non-Care Related Owner's Transactions**	0	0		
16	**Personal Expenses (Including Transportation)**	(4,178)	25		
17	**Non-Care Related Fees**	(1,100)	20		
18	**Fines and Penalties**	0	21		
19	**Entertainment**	0	20		
20	**Contributions**	(50)	20		
21	**Owner or Key-Man Insurance**	0	22		
22	**Special Legal Fees & Legal Retainers**	0	19		
23	**Malpractice Insurance for Individuals**	0	26		
24	**Bad Debt**	0	27		
25	**Fund Raising, Advertising and Promotional**	(35,078)	20		
26	**Income & IL Personal Property Replacement T**	0	0		
27	**Nurse Aide Training for Non-Employees**	0	13		
28	**Yellow Page Advertising**	(6,566)	20		
29	**Non-Paid Workers**	0	0		
30	**Donated Goods**	0	0		
31	**Amortization Expense**	0	0		
32	PAINTING & DECORATING	(1,145)	6		
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Line 1	0
Line 2	(195)
Line 3	0
Line 4	0
Line 5	0
Line 6	(1,145)
Line 7	0
Line 8	(1,340)
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	0
Line 20	(42,356)
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	(4,178)
Line 26	0
Line 27	0
Line 28	(46,777)
Line 29	(48,117)
Line 30	13,706
Line 31	0
Line 32	(45,470)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(31,870)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(79,706)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(195)	0	0	0	0	0	0	0	0	0	0	(195)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	197	0	0	0	0	0	0	0	0	0	197	5
6	Maintenance	(1,145)	0	0	0	0	0	0	0	0	0	0	(1,145)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,340)	197	0	0	0	0	0	0	0	0	0	(1,143)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(313,592)	0	0	0	0	0	0	0	0	0	(313,592)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	744	0	0	0	0	0	0	0	0	0	744	19
20	Fees, Subscriptions & Promotions	(42,594)	421	0	0	0	0	0	0	0	0	0	(42,173)	20
21	Clerical & General Office Expenses	0	(174,662)	0	0	0	0	0	0	0	0	0	(174,662)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	40	0	0	0	0	0	0	0	0	0	40	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,178)	0	0	0	0	0	0	0	0	0	0	(4,178)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	16,195	0	0	0	0	0	0	0	0	0	16,195	27
28	**TOTAL General Administration**	(46,772)	(470,854)	0	0	0	0	0	0	0	0	0	(517,626)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,112)	(470,657)	0	0	0	0	0	0	0	0	0	(518,769)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	13,796	0	0	0	0	0	0	0	0	0	0	13,796	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(45,470)	0	0	0	0	0	0	0	0	0	0	(45,470)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	5,988	0	0	0	0	0	0	0	0	0	5,988	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,674)	5,988	0	0	0	0	0	0	0	0	0	(25,686)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(79,786)	(464,669)	0	0	0	0	0	0	0	0	0	(544,455)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe SKOKIE MEADOWS N CENTER # # 0021385 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru Show Pgs 6E thru G Hide Pgs 6A thru G

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFFE	100%	SKOKIE MEADOWS II	SKOKIE	PREMIER MGMT	SKOKIE	BOOKKEEPING
		MONENCE MEADOWS	MONENCE			AND
		SHELDON MEADOWS	SHELDON			MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	17 MANAGEMENT FEES	$ 241,085			$	$ (241,085)	1	-341005
2	V	21 DIETHDIE CLERICAL SVS	282,500				(282,500)	2	-282500
3	V	5		PREMIER MANAGEMENT	100.00%	197	197	3	197
4	V	17		PREMIER MANAGEMENT	100.00%	27,412	27,412	4	27413
5	V	19		PREMIER MANAGEMENT	100.00%	744	744	5	744
6	V	20		PREMIER MANAGEMENT	100.00%	421	421	6	421
7	V	21		PREMIER MANAGEMENT	100.00%	44,880	44,880	7	44880
8	V	27		PREMIER MANAGEMENT	100.00%	16,195	16,195	8	16195
9	V	23		PREMIER MANAGEMENT	100.00%	40	40	9	40
10	V	25		PREMIER MANAGEMENT	100.00%	5,988	5,988	10	5988
11	V	21		PREMIER MANAGEMENT	100.00%	42,958	42,958	11	42958
12	V							12	
13	V							13	
14	Total		$ 603,585			$ 138,836	$ * (464,669)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6A

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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Print Page 6B

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STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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Print Page 6C

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STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	Administrative	100%	70,826	7	14.00	SALARY	$ 27,413	17-7	1
2			BANKING								2
3			FINANCE								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 27,413		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 679-7733
Fax Number: (847) 679-7736

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	10,000	5	$ 900	$	2,193	$ 197	1
2	17	OFFICER SALARY	PER RESIDENT DAY	10,000	5	125,000	125,000	2,193	27,413	2
3	19	DATA PROCESSING	PER RESIDENT DAY	10,000	5	3,394		2,193	744	3
4	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAY	10,000	5	1,919		2,193	421	4
5	21	CLERICAL	PER RESIDENT DAY	10,000	5	204,649	134,850	2,193	44,880	5
6	27	PAYROLL TAXES	PER RESIDENT DAY	10,000	5	73,847		2,193	16,195	6
7	23	SEMINARS	PER RESIDENT DAY	10,000	5	183		2,193	40	7
8	35	OFFICE RENT	PER RESIDENT DAY	10,000	5	27,304		2,193	5,988	8
9	21	CLERICAL	PER RESIDENT DAY	10,000	5	153,972	153,972	2,790	42,958	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 591,168	$ 413,822		$ 138,836	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	SOUTH TRUST		X	MORTGAGE	$42,972.00	04/23/96	$ 4,750,000	$ 3,590,603	04/20/21	0.098	$ 448,269	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICSN NATIONAL BANK		X	WORKING CAPITAL	INT ONLY		550,000	550,000	REVOLV	0.0875	57,215	6
7	SUCCESS NATIONAL BANK		X	WORKING CAPITAL				188,128			27,664	7
8	OLD KENT		X	WORKING CAPITAL				116,126			11,655	8
9	TOTAL Facility Related				$42,972.00		$ 5,300,000	$ 4,444,857			$ 544,803	9
	B. Non-Facility Related*											
10	TREASURY STOCKS				$3,351.00	12.95	215,000	71,183	11/02	0.08	7,149	10
11	REAL ESTATE TAX									0.18	6,451	11
12												12
13												13
14	TOTAL Non-Facility Related				$3,351.00		$ 215,000	$ 71,183			$ 13,600	14
15	TOTALS (line 9+line14)						$ 5,515,000	$ 4,516,040			$ 558,403	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	169,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	171,674	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,774	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	171,674	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 N/A Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	173,448	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	169,114	8
	1996	168,139	9
	1997	169,348	10
	1998	169,897	11
	1999	171,674	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,048 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 0 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING	0		$ 347,575	1
2					2
3	TOTALS			$ 347,575	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		90		$ 1,968,925	$ 62,506		$ 62,506	$	$ 586,012	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	IMPROVEMENT			1987	4,888	155	20	155		3,217	9
10	IMPROVEMENT			1988	3,196	101	31.5	101		1,287	10
11	IMPROVEMENT			1990	29,530	937	31.5	937		9,422	11
12	IMPROVEMENT			1991	20,962	665	31.5	665		6,347	12
13	IMPROVEMENT			1992	18,635	593	31.5	593		4,994	13
14	IMPROVEMENT			1993	50,200	1,594	31.5	1,594		12,545	14
15	IMPROVEMENT			1993	8,052	206	39	206		1,519	15
16	IMPROVEMENT			1994	71,864	1,843	39	1,843		12,095	16
17	FIRE DAMPERS			1995	4,980	128	39	128		752	17
18	NURSE STATION REMODELING			1995	70,129	1,798	39	1,798		9,815	18
19	CONCRETE WORK, PATIO, RAMPS			1995	21,904	1,460	39	1,460		8,213	19
20	RESIDENT ROOM REMODELING			1996	25,459	653	15	653		3,020	20
21	ROOF			1996	1,200	31	39	31		155	21
22	REHABBING 1ST FLOOR CORRIDOR LOWER WALLS			1997	14,497	372	39	372		1,318	22
23	DOOR			1997	1,455	37	39	37		146	23
24	ELEVATOR RENOVATION			1997	14,791	379	39	379		1,184	24
25	FIRE DAMPERS			1998	7,282	187	39	187		537	25
26	EXHAUST FANS			1998	4,135	106	39	106		281	26
27	FIRE DAMPERS & 21 GRILLS			1998	22,408	575	39	575		1,506	27
28	ACCESS PANELS & FIRE DAMPERS			1998	2,720	70	39	70		149	28
29	TILING			1999	14,344	368	39	368		567	29
30	KIL-BAR			1999	3,587	92	39	92		142	30
31	WALL HEATERS			1999	6,392	164	39	164		253	31
32	DOOR			1999	1,190	30	39	30		47	32
33	WINDOW REPLACEMENT			1999	61,410	1,575	39	1,575		2,428	33
34	SHOWER ROOM TILING			1999	9,206	236	39	236		364	34
35	GENERATOR			2000	62,880	1,143	27.5	1,143		1,143	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 78,004		$ 78,004	$	$ 669,458	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	TILLING			2000	6,052	110	27.5	110		110	9
10	WALL COVERING			2000	33,819	4,833	10	1,691	(3,142)	1,691	10
11											11
12											12
13											13
14											14
15											15
16											16
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 4,943		$ 1,801	$ (3,142)	$ 1,801	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 650,816	$ 35,156	$ 53,375	$ 18,219	10 YRS	$ 468,228	37
38	Current Year Purchases	13,791	1,971	690	(1,281)	10 YRS	690	38
39	Fully Depreciated Assets	41,925					41,925	39
40								40
41	TOTALS	$ 706,532	$ 37,127	$ 54,065	$ 16,938		$ 510,843	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 120,074	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 133,870	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 13,796	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,182,102	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 19,865 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PASSENGER VAN	1995 FORD SUPER	$ 545.00	$ 6,540	17
18	ADMINISTRATOR	1999 Cadillac Eldorado	600.00	7,200	18
19			472.00	944	19
20				6,042	20
21	TOTAL		$ ######	$ 20,726	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ___

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-8	hrs	$			$ 66,332	$		$ 66,332	1
2	Licensed Speech and Language Development Therapist	39-8	hrs				11,906			11,906	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-8	hrs				91,845			91,845	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$		$ 170,083	$		$ 170,083	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,678,542	$	1
2	Cash-Patient Deposits	3,094		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	639,609		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,194		6
7	Other Prepaid Expenses	1,594		7
8	Accounts Receivable (owners or related parties)	1,184,561		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,555,594	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	347,575		13
14	Buildings, at Historical Cost	1,968,925		14
15	Leasehold Improvements, at Historical Cost	563,348		15
16	Equipment, at Historical Cost	740,351		16
17	Accumulated Depreciation (book methods)	(1,359,571)		17
18	Deferred Charges	86,235		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Amort - Def Mtg Costs			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,346,863	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,902,457	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 89,590	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,907,559		29
30	Accrued Salaries Payable	81,404		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	171,674		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,250,227	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	968,834		39
40	Mortgage Payable	3,590,603		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,559,437	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,809,664	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (807,053)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,002,611	$	48

***(See instructions.)**

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Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (511,200)	1
2	Restatements (describe):	0	2
3	POST CLOSING CAPITAL ADJUSTMENTS	(334,377)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (845,577)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	38,524	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 38,524	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (807,053)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,674,599	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,674,599	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	134,892	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 134,892	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31,870	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 31,870	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**VENDING COMMISSIONS**	1,237	28
28a	**INVESTMENT LOSSES - SEE SCHEDULE**	(105,525)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (104,288)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 4,737,073	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 629,293	31
32	Health Care	1,810,666	32
33	General Administration	1,287,611	33
	B. Capital Expense		
34	Ownership	908,942	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	62,037	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,698,549	40
41	**Income before Income Taxes (line 30 minus line 40)****	38,524	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 38,524	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,240	$ 58,316	$ 26.03	1
2	Assistant Director of Nursing	1,696	1,776	36,064	20.31	2
3	Registered Nurses	23,881	26,815	504,119	18.80	3
4	Licensed Practical Nurses	4,098	4,507	72,614	16.11	4
5	Nurse Aides & Orderlies	68,219	71,590	608,516	8.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,234	7,738	58,888	7.61	10
11	Social Service Workers	6,771	7,011	77,116	11.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,333	18,044	161,858	8.97	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,565	13,401	102,783	7.67	18
19	Laundry	6,393	6,948	46,483	6.69	19
20	Administrator	3,710	3,896	116,309	29.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,122	4,519	43,674	9.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify Language Rehab	3,704	4,291	40,935	9.54	33
34	TOTAL (lines 1 - 33)	160,806	172,776	$ 1,927,675 *	$ 11.16	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,854	1-3	35
36	Medical Director	O	1,470	9-3	36
37	Medical Records Consultant	N	3,360	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,485	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consulta	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	968	11-3	44
45	Social Service Consultant	E	4,704	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULT	S	0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 19,841		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOAN WILLEY	ADMIN	0.00%	$ 79,627
GEORGEENE MOGYOROSSY	ASST. ADMIN.	0.00%	9,510
DOROTHY ANDERSON	ASST. ADMIN.	0.00%	27,172
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,309

B. Administrative - Other

Description	Amount
PREMIER MANAGEMENT - MANAGEMENT FEE	$ 341,005
TOTAL (agree to Schedule V, line 17, col. 3)	$ 341,005
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED		$ 60,330
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 60,330

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,719
Unemployment Compensation Insurance	13,345
FICA Taxes	153,570
Employee Health Insurance	80,521
Employee Meals	10,340
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	15,601
EMPLOYEE BENEFITS-OTHER	7,397
EMPLOYEE PHYSICAL EXAMS	16,697
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 318,190

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,865
Health Care Worker Background Chec	0
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	41,444
DUES & SUBSCRIPTIONS	8,163
LICENSES & PERMITS	1,648
TRUST FEES, CONTRIBUTIONS,etc.	1,150
MGMT CO ALLOCATION	421
LESS TRUST FEES, CONTRIB, etc.	(1,150)
Less: Public Relations Expense	( )
Non-allowable advertising	(35,078)
Yellow page advertising	(6,366)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,097

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
	0
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Num SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	6/97	$ 2,445	3 YRS	$ 408	$ 815	$ 815	$ 407	$	$	$	$	$
2	PAINT/DECORATI	6/00	1,862	3 YRS				310	621	621	310		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,307		$ 408	$ 815	$ 815	$ 717	$ 621	$ 621	$ 310	$	$

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Facility Name & ID Numbe SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost rep **YES**
If YES, give association name and amo **IL COUNCIL LONG TERM CARE $4430**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this per **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangeme **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. **62,037**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Secti **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **10,340** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportatio residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and pati **5%**
d. Have vehicle usage logs been maintair **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this co been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost repc **YES**
Attach invoices and a summary of services for all architect and appraisal fees

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